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U.S. Department of State
600 19th St, NW
Washington, DC 20006

Ref: DOS–2021–0034/RIN1400–AE87: Visas: Inadmissibility on Public Charge Grounds; Reopening of Public Comment Period

Dear Ms. Lage:

Thank you for the opportunity to submit comments on the above-captioned interim final rule (IFR). America’s Essential Hospitals appreciates the Department of State (DOS) reopening the public comment period for the IFR. We urge DOS to immediately rescind this 2019 IFR and issue a new rule that protects immigrant access to health care and other vital social services. By expanding the scope of benefits considered in determining eligibility for immigration status, the public charge definition from the 2019 IFR has been damaging to the nation’s health care system, marginalized patients, and state and local economies. The changes have been costly to federal, state, and local governments and detrimental to public health, and they reversed the substantial progress providers have made in delivering care to patients in the most appropriate and cost-effective settings. As exemplified during the COVID-19 pandemic, public health crises disproportionately affect people of color, including immigrants. Ensuring access to care for these populations is critical to the nation’s public health response.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to providing high-quality care to all, including underrepresented people and underserved communities. Filling a vital role in their communities, our more than 300 members provide a disproportionate share of the nation’s uncompensated care—that is, services the hospital provides for which it receives no reimbursement. The average essential hospital provides $56 million in uncompensated care annually—seven times more than other hospitals. Three-quarters of their patients are uninsured or covered by Medicare or Medicaid, and more than half of patients seen at essential hospitals are people of color. Our members provide state-of-the-art, patient-centered care while operating on financial margins half that of other hospitals—2.9 percent on average compared with 8.8 percent for all hospitals nationwide.1

Essential hospitals’ involvement in their communities goes beyond the direct provision of health care—they are leaders in tackling the social determinants of health that shape the well-being of marginalized communities. Part of their mission is a commitment to confronting structural racism as a public health threat. As an association, we are dedicated to

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acknowledging and addressing the deeply entrenched historical racism that plays a critical role in determining the health and well-being of each member of our members' communities. Harmful policies that deter immigration and prohibit the use of public benefits, particularly among people of color and low-income individuals, are emblematic of the structural racism embedded in the nation's laws. As DOS evaluates next steps in the rulemaking process, the agency should ensure the public charge definition is clear and equitable and does not unfairly target marginalized communities.

We applaud DOS for reopening the comment period to consider whether the 2019 IFR should be rescinded or revised. The public charge definition in the 2019 IFR caused fear and confusion among immigrants, putting these individuals and their families at risk and hampering the public health response to COVID-19. Patients forgoing public insurance programs and seeking care at hospitals without insurance strained the tight budgets of essential hospitals. The detrimental effects of the rule reached even further—it harmed the nation's health care system at large, resulting in increased health care costs and worse health outcomes. The impact of the 2019 IFR went beyond immigration to affect health care, housing, nutrition, employment, and other sectors of the economy. For the reasons outlined below, we urge DOS to rescind the 2019 IFR, remove the accompanying regulatory text from the Code of Federal Regulations, and adopt a regulatory public charge definition that does not deter individuals from accessing critical benefits for which they are eligible.

1. DOS should ensure its public charge definition is aligned with that of other federal agencies with jurisdiction over immigration.

While DOS oversees immigration applications from abroad through U.S. embassies and consulates, other federal agencies have jurisdiction over other aspects of immigration. The Department of Homeland Security (DHS) is responsible for individuals within the United States and at U.S. borders and ports, and the Department of Justice, through the Executive Office of Immigration Review and the Board of Immigration Appeals, has jurisdiction over deporting individuals already in the country. In 2019, DHS issued a final rule revising the longstanding definition of public charge in place since 1999 in field guidance. DOS in the 2019 IFR adopted the DHS definitions of public charge and public benefit, reasoning that a rule adopting the same definition of public charge was necessary for consistent adjudication of immigration applications within the U.S. and from abroad. Last year, a federal court vacated the 2019 DHS public charge rule, after which DHS rescinded the rule. DHS now is engaged in the rulemaking process to adopt a new regulatory definition of public charge. In the interest of consistency across federal agencies, DOS should rescind its IFR and adopt a new regulatory definition, which will ensure consistency with other federal agencies with overlapping jurisdiction on public charge determinations.

2. DOS should limit the types of public benefit programs considered in the public charge definition to exclude all in-kind benefit programs and clarify that family members' receipt of benefits is not considered in the public charge determination.

Under its longstanding policy before 2019, DOS only considered cash benefit programs and institutionalization for long-term care in the public charge determination. The 2019 IFR expanded the list of benefits to include multiple public programs spanning various government agencies, including non-emergency Medicaid benefits, housing benefits, and nutritional benefits. We urge DOS to exclude all in-kind public benefit programs, including all types of Medicaid benefits, from the public charge definition.

As the fallout from the 2019 final rule demonstrated, inclusion of public benefit programs in the public charge definition directly impacts immigrant access to vital benefits, such as Medicaid. Including these benefits in the public charge definition deters individuals, including citizens,
from enrolling in these programs and causes many current beneficiaries to disenroll or consider disenrolling.

Research on the public charge rule and public benefits confirmed immigrants and their U.S. citizen family members either disenrolled from or avoided enrolling in benefit programs, beginning even before the DHS and DOS rules were adopted. In 2019, nearly one-third of immigrant families with one family member who was not a permanent resident reported avoiding government benefit programs. Half of these families said they avoided enrolling in programs such as Medicaid and nutritional programs.\(^2\) A survey of immigrants in California reinforced this trend, finding that 25 percent of low-income immigrant adults avoided public benefit programs, including Medicaid and nutritional benefit programs, exacerbating food insecurity and hindering access to health care.\(^3\) Census data from 2019 has validated these studies, finding that U.S. citizen children with a noncitizen in their household also saw a sharp decline in enrollment in public benefit programs in 2019 (nearly 20 percent for Medicaid and 36 percent for nutritional assistance).\(^4\)

The inclusion of benefit programs in the public charge definition deters millions of marginalized individuals from seeking health care and other benefit programs directly tied to health and well-being. Medicaid covers 75 million people, the Supplemental Nutrition Assistance Program covers 42 million people, more than 10 million individuals receive federal rental assistance in, and approximately 1 million families live in public housing.\(^5\) Together, these programs form a key part of the social safety net, addressing social determinants of health that shape the lives of individuals in underserved communities plagued by the lingering effects of structural racism. The Medicaid program is an integral part of the American health care system, providing coverage of primary care, prenatal care, mental health and substance misuse services, specialty care, prescription drug coverage, and a variety of wraparound services. Medicaid also is a critical source of coverage for children, paying for routine check-ups, oral and vision care, and treatment for chronic conditions. Care reimbursed by Medicaid drives improved outcomes; reduces emergency department use and unnecessary hospitalizations; and helps decrease infant and child mortality rates.\(^6\) The benefits of Medicaid go beyond health care—individuals who receive Medicaid go on to become productive members of the workforce.

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and realize better employment and educational attainment, thus strengthening the economy.\textsuperscript{7} The program also lifts millions of individuals out of poverty, making them self-sufficient and less dependent on government programs in the long run.\textsuperscript{8} Similarly, nutritional and housing programs tackle food and housing insecurity, leading to better health outcomes.\textsuperscript{9} The sustained viability of and access to these programs is critical to empowering individuals to lift themselves out of poverty because of these programs’ link to general well-being, the economy, and educational attainment.

In addition to excluding the in-kind benefits added by the 2019 IFR, DOS should remove Medicaid long-term care benefits from the list of considerations in the public charge determination. The DOS Foreign Affairs Manual, in addition to including cash benefits, includes programs such as Medicaid that support noncitizens who receive long-term care. Long-term care includes a variety of health care, health-related, and social services that help individuals with disabilities, such as nursing home care. Medicaid is the primary payer of nursing home care, covering services not covered by Medicare and other payers. The Kaiser Family Foundation estimates that one in three people over the age of 65 will require nursing home care at some point in their lives.\textsuperscript{10} Given the importance of long-term care to the disabled and elderly population, DOS should not include these benefits in its revised public charge definition.

As demonstrated by the research cited above, the 2019 IFR not only directly affected noncitizens but also affected lawful permanent residents and U.S. citizens, who are lawfully eligible for these benefit programs. In addition to limiting the types of benefit programs in the public charge definition, the new rule should clearly state that the receipt of benefits by family members of applicants for immigrant status will not be considered in determining whether to grant the application. Excluding these vital benefit programs from the public charge definition, and clearly communicating that enrollment in these programs will not jeopardize immigration status of eligible family members, is critical to reassuring immigrant communities going forward.

3. DOS should ensure its future public charge regulations do not lead to increased costs and strain the budgets of essential hospitals.

As DOS drafts a new public charge regulation, it should ensure the benefits it includes in the public charge definition do not increase costs and strain the budgets of essential hospitals. The inclusion of health, nutritional, and housing benefits in the public charge definition resulted in reduced enrollment and disenrollment from public benefit programs, which in turn increased costs for health care providers. Specifically, the inclusion of Medicaid in the list of public benefits caused insurance losses, resulting in higher uninsurance rates and worse health outcomes.

An analysis of the 2018 DHS public charge proposed rule commissioned by America’s Essential Hospitals and performed by Manatt Health projected the far-reaching impact of including Medicaid benefits on hospital uncompensated care costs.\textsuperscript{11} Our analysis revealed more than 13

million Medicaid and Children’s Health Insurance Program (CHIP) enrollees would be subject to the chilling effect of the DHS rule, and hospitals could lose up to $17 billion annually in payments from these programs. This impact would be especially pronounced for essential hospitals. The $4.5 billion at-risk Medicaid and CHIP payments at essential hospitals make up 26 percent of the total at-risk amount, while essential hospitals constitute only 4 percent of all hospitals in the analysis. This disproportionate impact would be unsustainable for essential hospitals, which operate on margins narrower than the average hospital and provide seven times more uncompensated care—$56 million per hospital on average in 2019. While this analysis focused on the DHS proposed rule, the 2019 DOS IFR resulted in confusion and fear in immigrant communities mirroring the impact of the DHS rule and caused beneficiaries to drop coverage, resulting in an increase in uncompensated care. The ramifications of the DHS and DOS rules—which caused a significant erosion in trust among immigrant communities—are still being felt. If Medicaid is again included in the public charge definition, the chilling effect and the associated decline in Medicaid revenues would further increase uncompensated care and drive up costs for essential hospitals.

Given their role as large employers in their communities, the closure or scaling back of essential hospital operations would have a ripple effect on local and state economies. One study examined the potential economic loss to the United States resulting from disenrollment from health and nutritional benefit programs related to the 2019 public charge rules; it found the economic ripple effects of lost jobs could exceed $30 billion. For hospitals, loss of important Medicaid payments would affect operations. A shutdown or scaling back of hospital operations would reduce employment and the hospital’s economic contribution from spending on goods and services.

4. **DOS should exclude health, nutritional, and housing benefits from the public charge definition to ensure the rule does not undermine public health efforts.**

**DOS should ensure its future public charge regulations do not counteract public health efforts.** In reopening the public comment period, DOS seeks feedback on the effects of the 2019 IFR on public health measures and response to the COVID-19 pandemic. In addition to worse health outcomes for individuals directly affected by the loss of insurance, the inclusion of health and other benefits in the public charge policy will be felt by others in their communities and across the country. As people put off receiving necessary preventive and primary care, including immunizations, they will be at higher risk for acquiring communicable diseases that they might transmit to others in their communities. In this way, the inclusion of benefits in the public charge definition leads to a higher likelihood of outbreaks of transmissible diseases. The public health consequences of delaying health care and benefit application have been underscored by the COVID-19 pandemic, which has disproportionately affected people of color, including immigrants. The negative effects of COVID-19 go beyond health care to include economic impacts on people of color. As we continue to respond to COVID-19 and prepare for future public health emergencies, it is vital that all individuals who are eligible for health benefits enroll for these benefits and that people do not delay seeking necessary care.

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12 The analysis included CHIP benefits because DHS in the 2018 proposed rule sought comment on including CHIP benefits and because CHIP serves as a financing source for Medicaid coverage.


Further, inclusion of housing and nutritional benefits counteracts the progress that policymakers, health care providers, and other community partners have made in addressing factors beyond clinical care that influence a person’s health, including their social, economic, and environmental circumstances. Disenrollment from or delayed enrollment in these programs will inevitably drive up poverty rates, homelessness, and malnutrition, all of which lead to adverse health outcomes and undermine public health.

5. **DOS should consider the affidavit of support as sufficient evidence that an applicant for immigration status is unlikely to become a public charge and should apply the statutory factors in a nondiscriminatory and equitable manner.**

The public charge provision of the immigration statute lists factors immigration officers must consider when determining an individual’s likelihood of becoming a public charge: age; health; family status; assets, resources, and financial status; and education and skills. The statute also allows immigration officers to consider an affidavit of support in making a public charge determination. Affidavits of support are submitted by U.S. citizen or lawful permanent resident sponsors on behalf of applicants for immigration status, certifying that the applicant will not become a public charge and that the sponsor will use their financial resources to repay the cash value of any benefits the applicant uses in the future. **DOS should allow a properly filed affidavit of support to serve as sufficient evidence of the applicant overcoming the public charge ground of inadmissibility.** Giving full weight to the affidavit of support will provide consistency in the application of the public charge definition, as it will remove subjectivity in the application of other statutory factors by immigration officers. Further, it is consistent with DOS’ public charge regulations predating the 2019 IFR, which placed significant weight on the affidavit of support as a factor to overcome the public charge ground of inadmissibility.

**DOS should interpret other statutory factors in a way that does not disfavor people of color, women, and people with disabilities.** In the 2019 IFR, DOS provided more categories of evidence to evaluate under each of the statutory factors. For example, under the assets, resources, and financial status statutory factor, DOS finalized that a gross household income below 125 percent of the federal poverty guidelines (FPG) would be considered a negative factor. Household income over 250 percent of the FPG would be considered a heavily weighted positive factor. Placing excessive weight on income, either as a positive or negative factor, disfavors women and people of color, who on average have incomes lower than those of men and white people.16 DOS included other factors, such as proficiency in English and educational history, in the public charge test, which also are biased against the same populations, while not necessarily indicative of an individual’s likelihood to become dependent on the government for subsistence. Including such factors only serves to perpetuate the structural racism that results in disparities, such as the income gap.

Under DOS’ longstanding application of the public charge standard, which requires a medical examination, the agency evaluates individuals for physical or mental conditions, including serious disease or disability. This policy discriminates against disabled individuals and should be eliminated from the public charge test. **DOS should ensure the new public charge rule does not incorporate disability as a negative criterion, as such a policy has no relation to whether an individual is likely to become dependent on the government for subsistence and discriminates against disabled individuals.**

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6. **DOS should ensure the public charge regulations are clear to the general public, state and local agencies, and health care providers.**

DOS also should ensure public charge regulations are clear to all stakeholders and clearly communicate what the rule means for noncitizens, their ability to apply for benefits, and their applications for immigration status. The 2019 IFR rule was overly complex, requiring hospitals, community organizations, state and local agencies, and other stakeholders to invest significant resources in patient education. Moreover, DOS issued the IFR without first issuing a proposed rule or providing adequate notice, thus leaving stakeholders with no time to prepare their constituencies for the effects of the rule.

Hospitals are large, complex organizations with thousands of administrative and clinical staff across multiple units and physical locations of the hospital. Staff placed throughout these ambulatory networks interact with patients and receive questions from patients on the appropriateness of applying for benefits and receiving health care services.

Even before DHS or DOS issued their respective public charge rules, providers were fielding questions from patients on the implications of changes in immigration policy. Once the rules were issued, providers (who are not immigration experts) invested substantial staff time to understand the nuances of the rule, develop educational materials, and communicate the implications of the rule to their communities. Providers also had to train their front-line staff, including educating them about the rules and how they could affect patient eligibility and access to health care.

One of the first points of contact between hospitals and patients is the intake process, when hospitals collect information from patients on their insurance status. Understandably, patients might have questions for hospital intake staff about whether their receipt of benefits will imperil their current or future immigration status, although these staff are not necessarily the best equipped to answer such questions. In addition to intake staff, hospitals and other health care providers employ eligibility and enrollment counselors who assist patients with determining eligibility for benefits and processing their applications for insurance or other health-related programs. These staff are at multiple points of contact, including in hospitals’ vast networks of clinics and in their main campus. The 2019 public charge rule put hospital staff in the difficult position of having to tread the line between providing health care and legal advice, which goes beyond their current scope and responsibilities. Most of the questions they received were legal in nature and are not appropriate questions for hospital staff to answer.

In addition, state and local agencies already had established consumer-facing communications in the form of applications, application instructions, training for staff, and forms and posters displayed to applicants in public areas. These messages were based on the existing public charge definitions, which had been consistent since the 1990s. These states and localities had to recreate their communications materials to accurately capture the changes in the 2019 rules, only to switch back and forth between the 2019 rule and older guidance as DHS and DOS paused implementation of the rule in response to legal challenges.

**To avoid placing undue burden on hospitals, as well as state and local benefit administration agencies, DOS should ensure the rule is clear and engage in public education and communication campaigns to explain its implications.** These efforts should include materials from DOS clearly stating which benefits are in the public charge determination, which populations are affected by the public charge determination, and how receipt of benefits could affect immigration status. After the 2019 IFR, this work was primarily done by providers and state and local agencies. To ensure consistent and accurate messaging about the implications of the rule, DOS should lead efforts to publish these materials. Further, DOS should work with federal and state agencies responsible for the various benefit programs (such as the Centers for Medicare & Medicaid Services and state Medicaid agencies) to clearly encourage current and prospective beneficiaries of Medicaid and other benefit programs to
enroll in these programs when appropriate. For example, CMS’ Center for Medicaid and CHIP Services (CMCS) in July released an informational bulletin to states informing them that the 2019 public charge rule had been rescinded and encouraging them to safeguard applicant and beneficiary information. We commend CMCS for this effort and believe DOS should work with CMCS and other relevant agencies once a new rule is finalized to issue similar communications on the importance of enrolling in public benefits.

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America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO